IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

PAUL LUCERO,

Plaintiff,

vs. **No CIV 09-744 DJS/RHS**

MCKINLEY COUNTY, a Municipal Entity Organized Under the Laws of the State of New Mexico and its subsidiary the McKinley County Detention Center, SERGEANT JONES, an employee of the McKinley County Detention Center, Individually and in Defendant's official capacity, DONNA GOODRICH, Warden/Director of the McKinley County Detention Center, Individually and in Defendant's official capacity,

Defendants.

DEFENDANT COUNTY'S
FIRST REQUEST FOR PRODUCTION OF DOCUMENTS
TO PLAINTIFF PAUL LUCERO

TO: PAUL LUCERO
c /o Roman Romero
1001 5th St NW
Albuquerque, NM 87102-2140
(505) 345-9616
(505) 243-8826 fax

Pursuant to Fed.R.Civ. P. 34, Defendant Board of County Commissioners of McKinley County, by and through its attorneys, Slease & Martinez, P.A., request that Plaintiff PAUL LUCERO produce the following requested documents and tangible items and make them available for inspection and copying at the offices of Slease & Martinez, P.A. 105 14TH Street SW, Albuquerque, New Mexico, within thirty (30) days of the date of service hereof.

DOCUMENTS REQUESTED

REQUEST NO. 1: All medical, psychiatric, psychological and drug bills or other related medical charges for treatment of the injuries alleged to have been sustained as a result of the acts alleged in Plaintiff's Complaint.

RESPONSE:

REQUEST NO. 2: Any and all hospital notes, doctor's notes, nurse's notes, medical reports, psychiatric or psychological reports or tests, or other statements by any treating physician who saw or treated Plaintiff for his injuries alleged to have been incurred as a result of the incidents described in Plaintiff's Complaint.

RESPONSE:

REQUEST NO. 3: Any and all photographs, videotapes, models, plats or drawings pertaining to any allegations involved in this case.

RESPONSE:

REQUEST NO. 4: Any and all witness statements, whether written or recorded, pertaining to any allegations involved in this case, including any statement taken from any of the Defendants, but not including any statements made by the Plaintiff to his attorneys.

RESPONSE:

REQUEST NO. 5: All statements, correspondence, memoranda, notes or other documents obtained from any person having or purporting to have knowledge relating to the allegations of the Complaint.

RESPONSE:

REQUEST NO. 6: If the Plaintiff is claiming any lost income, lost economic opportunities or lost employment opportunities in this matter, please provide Plaintiff's personal state and federal income tax returns for the past seven (7) years, including all attachments to such returns. If returns are not available for a particular year, please sign the enclosed form.

RESPONSE:

REQUEST NO. 7: To the extent not previously requested, any and all documents reflecting or pertaining in any way to any alleged damages, including, but not limited to, all documents which you anticipate introducing at trial in support of any claim for damages.

RESPONSE:

REQUEST NO. 8: All documents or tangible items which are referred to in your answers to Defendant's First Set of Interrogatories, and all documents or other tangible items upon which you relied in answering Defendant's First Set of Interrogatories.

RESPONSE:

REQUEST NO. 9: All reports, correspondence, memoranda or other documents which you have received from or provided to any expert retained to testify at trial.

RESPONSE:

REQUEST NO. 10: All documents or tangible items which may be introduced at trial.

RESPONSE:

REQUEST NO. 11: Any and all other documents relating in any way to any of the allegations of the Complaint.

RESPONSE:

REQUEST NO. 12: If any documents requested in Request for Production Nos. 1 through 11 are not produced based upon any asserted privilege, list each and every document withheld with sufficient particularity so that the claim of privilege may be evaluated.

RESPONSE:

REQUEST NO. 13: To the extent that you have not already done so, please sign the enclosed Releases so that the Defendant can obtain your medical and psychological records.

RESPONSE:

REQUEST NO. 14: Copies of all pleadings or documents from any other lawsuits, complaints, administrative actions, or other actions or claims made by you, on your behalf or against you.

RESPONSE:

REQUEST NO. 15: If you are claiming any lost income, lost earning potential or lost employment opportunities, please sign and produce the enclosed form authorizing the Defendants to obtain your employment records.

RESPONSE:

Respectfully submitted,

SLEASE & MARTINEZ, P.A.

By_____

WILLIAM D. SLEASE
JONLYN M. MARTINEZ
Attorneys for Defendant County
P.O. Box 1805
Albuquerque, NM 87103-1805
(505) 247-9488

Exhibit A

AUTHORIZATION FOR RELEASE OF
EMPLOYMENT RECORDS

TO:

Re: PAUL LUCERO
Soc. Sec. No.: _____
Date of Birth: _____

This, or any photostatic copy hereof, will authorize Slease & Martinez, P.A., or any representative of Slease & Martinez, P.A., to examine and obtain copies of any and all documents or other tangible things as they may request, which pertain to PAUL LUCERO'S employment.

This will further authorize you to deliver to the above-named attorneys any and all records contained in any personnel file maintained by you concerning PAUL LUCERO'S employment, including but not limited to employment evaluations, disciplinary actions, time and attendance records, wage and salary records and any records relating to any physical or psychological examinations, fitness for duty, accidents, injuries, illnesses or disabilities.

Dated and signed this _____ day of _____, 2009.

_____
PAUL LUCERO

STATE OF NEW MEXICO)
) ss.
COUNTY OF _____)

This instrument was acknowledged before me on _____, 2009 by PAUL LUCERO.

_____
Notary Public

My Commission Expires:

_____

HIPAA

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

MEDICAL RECORDS

THIS DOCUMENT DOES NOT AUTHORIZE RELEASE OF ANY RECORDS CONCERNING OR RELATED TO ANY ALCOHOL, DRUG, HIV OR PSYCHIATRIC CARE, TESTING OR TREATMENT

Patient name: PAUL LUCERO

D.O.B.: _____ **S.S.N.:** _____

Dates of Treatment: beginning March 1, 2004 through Present
[relevant time period must be inserted]

AUTHORIZATION:

I, PAUL LUCERO, authorize the disclosure of my protected health information as described herein.

1. I authorize the following person(s) and/or organization(s) to disclose the protected health information described in paragraph 3.

[individual medical provider name must be inserted]

2. I authorize the following person(s) and/or organization(s) to receive the protected health information described in paragraph 3.

Slease & Martinez, P.A. P.O. Box 1805 Albuquerque, NM 87103-1805

[individual firm or lawyer must be inserted]

3. The records authorized to be released include:

all medical and billing records including without limitation: medical reports, clinical notes, nurse's notes, history of injury, subjective and objective complaints, x-rays, x-ray reports or interpretations, other diagnostic tests (including a copy of the report), diagnosis and prognosis; if applicable, emergency room records or logs, history and physical examination report, laboratory reports, tissue committee reports, reports of operation, operation logs, progress notes, doctors' orders, nurse's notes, physical therapy records, admission and discharge summaries,

and all out-patient records; hospital bills, bills for the services you have rendered, bills for medication; and any other documents, records, or information in your possession relative to my past, present or future physical condition.

4. I expressly waive any laws, regulations and rules of ethics which might prevent any health care provider who has examined or treated me from disclosing my records pursuant to this Authorization.

5. The purpose of this Authorization to relates to a legal action now pending in the United States District Court for the District of New Mexico.

6. I understand that I may revoke this Authorization at any time by sending a letter to the person or organization listed in paragraph one (1), except to the extent that such person(s) and/or organization(s) may have already taken action in reliance on this Authorization. If I do not sign, or if I later revoke, this Authorization, the services provided to me by such person or organization will not be affected in any way.

7. This Authorization expires one year from its date of execution.

8. THIS AUTHORIZATION DOES NOT PERMIT THE PERSON OR ORGANIZATION LISTED IN PARAGRAPH TWO (2) TO OBTAIN OR REQUEST FROM THE MEDICAL PROVIDER IDENTIFIED IN PARAGRAPH ONE (1) ORAL STATEMENTS, OPINIONS, INTERVIEWS, OR REPORTS THAT ARE NOT ALREADY IN EXISTENCE.

9. Copying costs will be borne by the person or organization named in paragraph two (2).

10. A photocopy or facsimile of this Authorization is as valid as an original.

11. I understand that a potential exists for information that is disclosed pursuant to this Authorization to be subject to re-disclosure by the recipient and therefore be no longer protected by federal confidentiality rules.

SIGNATURE OF PATIENT OR
AUTHORIZED REPRESENTATIVE: _____

DATE OF SIGNATURE: _____

HIPAA
AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION
MEDICAL AND MENTAL HEALTH RECORDS

Patient name: PAUL LUCERO

D.O.B.: _____ **S.S.N.:** _____

Dates of Treatment: beginning March 1, 2004 through Present
[relevant time period must be inserted]

AUTHORIZATION:

I, PAUL LUCERO, authorize the disclosure of my protected health information as described herein.

1. I authorize the following person(s) and/or organization(s) to disclose the protected health information described in paragraph 3.

[individual medical provider name must be inserted]

2. I authorize the following person(s) and/or organization(s) to receive the protected health information described in paragraph 3.

Slease & Martinez, P.A. P.O. Box 1805 Albuquerque, NM 87103-1805

[individual firm or lawyer must be inserted]

3. The records authorized to be released include:

[**X**] complete copy of medical records

[**X**] test results

[**X**] other

ANY RECORDS CONCERNING OR RELATED TO ANY ALCOHOL, DRUG, HIV OR PSYCHIATRIC CARE, TESTING OR TREATMENT

4. I expressly waive any laws, regulations and rules of ethics which might prevent any health care provider who has examined or treated me from disclosing my records pursuant to this Authorization.

5. The purpose of this Authorization relates to a legal action now pending in the Second Judicial District Court for the District of New Mexico.

6. I understand that I may revoke this Authorization at any time by sending a letter to the person or organization listed in paragraph one (1), except to the extent that such person(s) and/or organization(s) may have already taken action in reliance on this Authorization. If I do not sign, or if I later revoke, this Authorization, the services provided to me by such person or organization will not be affected in any way.

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9. Copying costs will be borne by the person or organization named in paragraph two (2).

10. A photocopy or facsimile of this Authorization is as valid as an original.

11. I understand that I have a right to examine the information to be disclosed, unless deemed that such disclosure is not in my best interest.

12. I understand that a potential exists for information that is disclosed pursuant to this Authorization to be subject to re-disclosure by the recipient and therefore be no longer protected by federal confidentiality rules.

SIGNATURE OF PATIENT OR
AUTHORIZED REPRESENTATIVE: _____

DATE OF SIGNATURE: _____

_____